

**Benchmark 1: Maternal and Newborn Health**

Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Definition of Improvement	Persons responsible	Source/Justification	Population	Schedule (Frequency)	Data Analysis Plan and Use of Data for CQI
1) Prenatal care	% of pregnant women who received prenatal health care.	# of enrolled pregnant women scoring 4 or 5 on LSP 17/# enrolled pregnant women enrolled in program	LSP #17	Increase in the % of enrolled pregnant women receiving prenatal care (4 or 5 on scale) by comparing cohort one to subsequent cohorts. Year one pregnant women will be grouped in a cohort and compared to subsequent years. Successful maintenance will be defined as 95% of women scoring 4 or 5 on #17 of the LSP.	HV	Life Skills Progression Instrument (Please see the narrative of this section to read more about this tool)	Enrolled pregnant women	Enrollment, every 6 months until case closed.	Data will be reviewed at enrollment and every six months thereafter and at case closing. An analysis will be completed down to the home visitor level. System level and community level barriers to accessing prenatal care will be addressed by implementing new strategies to overcome these barriers. Individual worker barriers will be addressed through supervision and professional development
2) Parental use of alcohol, tobacco, or illicit drugs	% of parents who decrease their use of tobacco	# of parents who score 1 to 3 at enrollment and show increase on LSP 25/# of parents who are smokers at enrollment as measured on the LSP	LSP #25	Decrease in the % of parents who use tobacco from enrollment to their annual anniversary LSP that is completed closest to the time of reporting. The LSP completed at enrollment will be considered the pre-test and compared to the LSP completed at the yearly anniversary closest to the time of	HV	Life Skills Progression Instrument (Please see the narrative of this section to read more about this tool)	Enrolled parents who use tobacco	Enrollment, every 6 months until case closed.	This is a sensitive topic that will most likely be artificially scored higher at the time of enrollment due to the home visitor not having the intimate knowledge of the family to score this accurately. It is anticipated that scores at the first six month interval will actually decrease as the home visitor will have more accurate knowledge of the family. This is why we will measure this construct at yearly intervals although we will monitor more frequently. System level and community level barriers to accessing treatment will be addressed by implementing new strategies to overcome these barriers. Individual worker barriers will be addressed through supervision and professional development.

Iowa Benchmark Plan – Final 2-1-12

				reporting as the post test. Successful maintenance will be defined as scoring a 4 or 5 on the LSP.					
3) Preconception care	% of mothers reporting that they have received information about preconception care, as defined by the CDC, between births of their child(ren) has increased.	# of non-pregnant mothers, that are planning or at risk for an unplanned pregnancy who report receiving information about preconception care from the home visitor /# of non-pregnant women who are planning or at risk for an unplanned pregnancy	Primary source home visitor documentation of services provided. Interview based on CDC preconception guidelines.	Increase in the % of mothers who receive information about preconception care within one year post-partum from Cohort one to subsequent cohorts. Year one women will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 95% or greater of mothers receive information about preconception care.	HV	Home visitor documentation in family file of education provided	Non-pregnant women that are planning or at risk for an unplanned pregnancy	Every six months, post enrollment	This measure will require the home visitor to ask questions about the health care services that women are receiving from their health care provider. By asking the questions we are also assisting women to understand and initiate conversations with their health care provider about preconception care. Non-health prepared home visitors may need additional supervisor support including training to feel comfortable with these questions. Questions will be incorporated in the REDCap system. There may be system or community level barriers that are uncovered in this process that will need to be addressed by implementing new strategies.
4) Inter-birth intervals	% of women who receive information on inter-birth intervals, as defined by the CDC.	# of women who are planning or at-risk for an unplanned pregnancy who report receiving information on inter-birth intervals/ # of women who are planning or at-risk for an	Primary Source is home visitor documentation of services provided. Interview based on CDC inter-birth intervals.	Increase in the % of women who receive information about inter-birth intervals within one year post-partum from cohort one to subsequent cohorts. Year one women will be grouped into	HV	home visitor documentation in family file of education provided	Women that are planning or at-risk for an unplanned pregnancy. Includes mothers of birthing age that are capable of a pregnancy. It does not include women	Every six months, post enrollment	The baseline will be determined in the first year of service. We will also analyze the state average for this measure and compare between our targeted communities and neighboring communities as well. The goal is to increase the amount of time between subsequent pregnancies with a minimum standard of 24 months. Questions regarding children's birthdates will be incorporated into the REDCap system. The parent interview

Iowa Benchmark Plan – Final 2-1-12

		unplanned pregnancy.		a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 95% or greater of mothers receive information about inter-birth intervals.			that are sterilized.		regarding preconception care will also assist in providing education regarding the rationale for spacing between pregnancies. Family cultural will also need to be considered as a factor including religious beliefs. Home visitors will need to particularly sensitive in addressing this topic.
5) Screening for maternal depressive symptoms	Percentage of enrolled postpartum women that are screened for postpartum depression	# of postpartum women that are screened for postpartum depression/# of enrolled postpartum women	Edinburg Postnatal Depression Screening	Increase or maintain the % of women screened for postpartum depression within six months post-partum from cohort one to subsequent cohorts. Year one women will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 95% or greater of women are screened for postpartum depression.	HV	EPDS (please see narrative of this section for more information on this tool)	Postpartum women	The EPDS is designed to be given postpartum at the ten week mark. Additional screenings may be warranted based on individual circumstances including past history.	The baseline will be determined in the first year of service. We will also analyze the state average for this measure and compare between our targeted communities and neighboring communities as well. An additional goal for CQI purposes is to increase the percentage of women that are screened and that receive treatment for postpartum depression. We will also analyze for system and community level barriers such as availability of treatment and put in place strategies to overcome any barriers. Due to the sensitive nature of this construct we will also pay close attention to home visitors that seem to have few if any families score high on the EPDS. This may be an indication of a need for additional training for the worker.
6) Breastfeeding	percentage of moms that breastfeed their baby	#of mothers who breastfeed their baby for any length of time/total # of mothers who	Primary source – parent interview	Increase the percentage of mothers that breastfeed their baby for any length of time	HV	Parent Interview	Mothers of newborns	As needed within 30 days of the child's birth.	Self reporting can be impacted by the relationship between the home visitor and the parent. Home Visitors may also use observation but determination if this measure is being met or not will be dependent

Iowa Benchmark Plan – Final 2-1-12

		have given birth and are parenting newborns		by comparing cohort 1 to cohort 2. Year one women will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance will be defined when 90% of mothers choose to breastfeed their baby for any length of time.					upon the parent interview. The baseline will be determined in the first year of service. We will also analyze state and community level data compared to the targeted community data for trends. System and community level barriers to breastfeeding will be addressed through new strategies. Individual worker barriers may be addressed through supervision or professional development. Cultural customs must also be considered when analyzing this measure. For CQI purposes we will also measure the mothers that continue to breastfeed at their baby's six month birthday. Our goal will be to increase the percentage s of mothers that choose to breastfeed their babies and also to increase the length of time the baby is breastfeed.
7) Well-child visits	Percentage of enrolled children that are in compliance with the CDC recommended immunization schedule at twelve months.	# of children in compliance with the CDC recommended immunization schedule at 12 months/ # of 12 month old enrolled children	Primary source – parent interview	Increase the percentage of children in compliance with the CDC recommended immunization schedule at 12 months by comparing cohort 1 to cohort 2. Year one children will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 95% or greater of 12 month old children are in compliance with the CDC	HV	Parent Interview	Parent(s) of twelve month olds	As needed within 30 days before or after the child's twelve month birthday.	The baseline will be determined in the first year of service. We will also analyze state and community level data compared to the targeted community data for trends. System and community level barriers for immunization will be addressed through new strategies. Individual worker barriers may be addressed through supervision or professional development. Cultural issues will also need to be taken into consideration.

Iowa Benchmark Plan – Final 2-1-12

				recommended immunization schedule.					
8) Maternal and child health insurance status	percentage of mothers and children with health insurance	# of mothers and children who have health insurance/# of mothers and children enrolled in the program	Primary source – parent interview	Increase the percentage of mothers and children with health insurance at 6 months post enrollment, by comparing cohort 1 to cohort 2. Year one mothers will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 95% or greater of mothers and children have health insurance.	HV	Parent Interview	Mothers and children 0 – kindergarten entry	Annually	Timing of gathering this information may impact the data. For instance a mother may have had health insurance for the previous 11 months but recently lost her coverage and has not yet been approved for coverage in the state system at the time of the interview. Technically the mother is without health insurance and yet if approved for state coverage, it will be retroactive resulting in no gap in coverage. Employment fluctuations may have a significant impact on this measure. . Eligibility guidelines for the state health insurance program for children may be reduced rendering children ineligible for coverage but not eligible for Medicaid. Systematic and community level data will be analyzed for these trends.
Benchmark 2: Child Injuries, abuse, neglect, maltreatment									
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Definition of Improvement	Persons responsible	Source	Population	Schedule (Frequency)	Data Analysis Plan
9) Visits for children in the emergency department from all causes	percentage of children 0 – 5 that have not yet entered kindergarten, receiving health care in an emergency room of the hospital	# of children, 0 – 5, that have not yet entered kindergarten receiving health care in an emergency room of a hospital/# of children 0 – 5 (not yet entered kindergarten) enrolled in the program	Primary source – parent interview	Decrease the percentage of children receiving health care in an emergency room of a hospital by one year post enrollment, comparing cohort 1 and cohort 2. Year one children will be grouped into a cohort to	HV	Parent Interview	Enrolled children 0 – kindergarten entry	monthly	The increased frequency in gathering this information will assist in parents remembering with accuracy if their child has been seen in the ER. The data will be analyzed for community level trends and compared with available health care options in the community such as urgent care or the lack of a medical home. Home Visitors will work with families to establish a medical home for their children for all health care needs. Home Visitors will be instructed to ask parents for the underlying reason why their child was seen in the ER versus by their medical provider to

Iowa Benchmark Plan – Final 2-1-12

				create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance of this measure will be defined when 5% or fewer children receive health care in an emergency room of the hospital.					establish if there are underlying issues within the community or with the family.
10) Visits for mothers the emergency department from all causes	percentage of mothers receiving health care in an emergency room of the hospital	# of mothers receiving health care in an emergency room of the hospital/# of mothers enrolled in the program	Primary source – parent interview	Decrease the percentage of mothers' receiving health care in an emergency room at one year post enrollment, by comparing cohort 1 to cohort 2. Year one mothers will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance will be defined when 5% or fewer mothers receive health care in an emergency room of a hospital.	HV	Parent Interview	Enrolled mothers	monthly	Please see the data analysis plan for the construct above. The same applies to this construct with a focus on mothers.
11) Information provided or training on	percentage of families that report that they	# of families that receive childhood	Home Visitor documentation of services	Increase the percentage of families that	HV	Home Visitor documentation in family file of services	Enrolled families	Every six months post enrollment.	This construct does not measure change in behavior only that information has been given. For CQI

Iowa Benchmark Plan – Final 2-1-12

prevention of child injuries	receive childhood injury prevention information has increased	injury prevention information / # of enrolled families	provided	receive childhood injury prevention information at six months post enrollment, by comparing cohort 1 to cohort 2. Year one families will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 95% or greater of families report they have received childhood injury prevention		provided			purposes, we will also measure effectiveness of injury prevention materials by surveying parents one month after information was given to determine knowledge gained. Injury prevention lessons including materials will be developmental appropriate and based on the family's needs. Materials that do not demonstrate that they were effective at imparting knowledge will be revised. In addition home visitors that show a trend in an inability to impart knowledge will be given additional supervision and training and re-evaluated.
12) Incidence of child injuries requiring medical treatment	percentage of children 0 – kindergarten entry, suffering injuries that require medical treatment from a recognized medical professional	# of children 0 – kindergarten entry, suffering injuries that require medical treatment from a recognized medical professional/ # of children 0 – kindergarten entry enrolled	Primary source – parent interview	Decrease the percentage of children suffering injuries that require medical treatment from a recognized medical professional at one year post enrollment, comparing cohort 1 to cohort 2. Year one children will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. I	HV	Parent Interview	Enrolled children 0- kindergarten entry	monthly	The frequency is set at monthly to assist in assuring accuracy of the data. For CQI purposes this data may be cross-referenced with child maltreatment data for injuries that fall within that category. Also for CQI purposes, unintentional injuries may result in more frequent injury prevention lessons and home visit safety analysis to increase the parent's ability to create and maintain a safe home environment. Analysis may demonstrate a parent's lack of understanding about child development therefore resulting in increased injuries. Supervisors should complete a case review when there is more than one child injury in the family per year. The supervisor can than provide consultation to the home visitor regarding the course of action. In addition from a state perspective we will analyze the data to see if the injuries are farm related and if new strategies need to be in

Iowa Benchmark Plan – Final 2-1-12

				Successful maintenance is defined when 5% or fewer children have injuries requiring medical treatment.					place to prevent farm related injuries.
13) Reported suspected maltreatment for children in the program	percentage of reported suspected maltreatment of children 0 – kindergarten entry	# of reported suspected maltreatment of children 0 – kindergarten entry/# of enrolled children 0 to kindergarten entry	Primary source – parent interview	Decrease the percentage of children with reported suspected maltreatment by one year post enrollment, comparing cohort 1 to cohort 2. Year one children will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 5% or fewer child have reports of suspected maltreatment.	HV	Parent Interview	Children 0 to kindergarten entry	quarterly	This construct will be challenging to report with accuracy. Reports that are not substantiated are not available from DHS for cross reference with parent interview results. We will compare the results to reports of unsubstantiated maltreatment in the county. Analysis may result in systematic, community level or sub-target level issues arising. The response will vary depending upon the level of the issue discovered. Parents may not be aware that a report has been filed against them if it is dismissed at the DHS investigative level.
14) Reported substantiated maltreatment	percentage of reported substantiated maltreatment of children 0 – kindergarten entry enrolled in the home visiting program	# of reported substantiated maltreatment of children 0 – kindergarten entry / # of 0 – kindergarten entry children enrolled in the home visiting program	Iowa DHS administrative data	Decrease the percentage of enrolled children with substantiated maltreatment by one year post enrollment, comparing cohort 1 to cohort 2. Year one children will be grouped into a cohort to create a	Data Lead	Iowa DHS administrative data	Children 0 to kindergarten entry	quarterly	The Data Lead has access to DHS administrative data through a research agreement. The research agreement will need to be expanded to include this information.  Analysis will include system level, community level and worker level for trends. System and community level negative trends will result in new strategies being implemented. Individual worker trends will result in additional supervision and/or professional development.



Iowa Benchmark Plan – Final 2-1-12

				baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance will be defined when 5% or fewer children have substantiated reports of maltreatment.					Families with a substantiated report will be asked to sign a release of information to coordinate services with CPS
15) First-time victims of maltreatment	percentage of reported first time victims of maltreatment of children 0 – kindergarten entry enrolled in the home visiting program	# of reported first time victims of maltreatment of children 0 – kindergarten entry/ # of children enrolled in the program 0 to Kindergarten entry	Iowa DHS administrative data	Decrease the percentage of children that are first time victims of child maltreatment by one year post enrollment, comparing cohort 1 to cohort 2. Year one children will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance will be defined when 2% or fewer children are first-time victims of maltreatment.	Data Lead	Iowa DHS administrative data	Children 0 to kindergarten entry	quarterly	<p>The Data Lead has access to DHS administrative data through a research agreement. The research agreement will need to be expanded to include this information.</p> <p>Analysis will include system level, community level and worker level for trends. System and community level negative trends will result in new strategies being implemented. Individual worker trends will result in additional supervision and/or professional development.</p> <p>Families with a substantiated report will be asked to sign a release of information to coordinate services with CPS</p>
<b>Benchmark 3: School Readiness</b>									
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Definition of Improvement	Persons responsible	Source	Population	Schedule (Frequency)	Data Analysis Plan
16) Parent support for children's learning and	% of parents that show support for their child's learning	# of families that show support for their child's	Life Skills Progression Instrument	Improvement will be measured by the percentage	HV	LSP, scale #7 Please see narrative in section five that provides additional	Parents enrolled in the program	Enrollment, every 6 months until case closed. The LSP	LSP scores will be entered in the state data system at enrollment and then at six month intervals. Data will be analyzed for trends particular to a

Iowa Benchmark Plan – Final 2-1-12

development	and development	learning and development/ # of families enrolled in the program		of parents that increase their score on scale 7 of the LSP or maintain a score of 4 or 5 on the LSP from enrollment to their annual anniversary LSP that is completed closest to the time of reporting. The LSP completed at enrollment will be considered the pre-test and compared to the LSP completed at the yearly anniversary closest to the time of reporting as the post test. Successful maintenance will be defined as scoring a 4 or 5 on the LSP.		information on the LSP		that is completed at 12 months will be considered the post test for year one. For future years the LSP that is completed approximately 12 months after the year one will be the post-test to measure progress over multiple years.	certain demographic, certain geographic location and down to the individual home visitor level. Concerning trends from individual home visitors will be analyzed for appropriate action ranging from more intense supervision to professional development opportunities for the home visitor.
17) Parent knowledge of child development and of their child's developmental progress	% of parents that show knowledge of their child's developmental progress	# of parents that show knowledge of their child's developmental progress/ # of parents enrolled in the program	Life Skills Progression Instrument	Improvement will be measured by the percentage of parents that increase their score on scale 7 of the LSP or maintain a score of 4 or 5 on the LSP from enrollment to their annual anniversary LSP that is completed closest to the time of	HV	LSP, scale #7 Please see narrative in section five that provides additional information on the LSP	Parents enrolled in the program	Enrollment, every 6 months until case closed. The LSP that is completed at 12 months will be considered the post test for year one. For future years the LSP that is completed approximately 12 months after the year one will be the post-test to measure	LSP scores will be entered in the state data system at enrollment and then at six month intervals. Data will be analyzed for trends particular to a certain demographic, certain geographic location and down to the individual home visitor level. Concerning trends from individual home visitors will be analyzed for appropriate action ranging from more intense supervision to professional development opportunities for the home visitor. For additional CQI purposes, a sampling of ASQ scores completed by the parents and compared to the home visitor scores will be analyzed. In addition when there is more than

Iowa Benchmark Plan – Final 2-1-12

				reporting. The LSP completed at enrollment will be considered the pre-test and compared to the LSP completed at the yearly anniversary closest to the time of reporting				progress over multiple years.	a ten percent deviation, additional supervision in the form of consultation will be provided
18) Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)	% of parents that demonstrate appropriate discipline	# of parents that demonstrate appropriate discipline/ # of parent enrolled in the program	Life Skills Progression Instrument	Improvement will be measured by the number of parents that increase their score on scale 6 of the LSP or maintain a score of 4 or 5 on the LSP from enrollment to their annual anniversary LSP that is completed closest to the time of reporting. The LSP completed at enrollment will be considered the pre-test and compared to the LSP completed at the yearly anniversary closest to the time of reporting.	HV	LSP, scale #6 Please see narrative in section five that provides additional information on the LSP	Parents enrolled in the program	Enrollment, every 6 months until case closed. The LSP that is completed at 12 months will be considered the post test for year one. For future years the LSP that is completed approximately 12 months after the year one will be the post-test to measure progress over multiple years.	LSP scores will be entered in the state data system at enrollment and then at six month intervals. Data will be analyzed for trends particular to a certain demographic, certain geographic location and down to the individual home visitor level. Concerning trends from individual home visitors will be analyzed for appropriate action ranging from more intense supervision to professional development opportunities for the home visitor. For additional CQI purposes, the state will compare low (0 – 3) LSP scores on scales 6 with substantiated maltreatment reports.
19) Parent emotional well-being or parenting stress (note: <u>some</u> of these data may	% of parents indicating a high stress level on the Child Health and Development Record (CHDR)	# of parents who reported needing assistance with stress-related issues that now report declining	Child Health and Development Record (CHDR)	After a family is identified as needing assistance with stress-related issues in the home and these	HV	CHDR parental stress surveillance questions	Parents enrolled in the program	Intervals in conjunction with CDC recommended schedule for well child exams. For	Results of the CHDR will be used to formulate appropriate lesson plans with an emphasis in areas that need strengthening. State and community level trends will be analyzed for system and community barriers and strategies implemented to overcome

Iowa Benchmark Plan – Final 2-1-12

also be captured for maternal health under that benchmark area).	surveillance questions	stress on the CHDR/ # of parents indicating a high stress level on the Child Health and Development Record (CHDR) surveillance questions		issues are being addressed through community-based resource, then the level of stress will be reported by the parent as decreased. The CHDR completed first after enrollment will be considered the pre-test and the one at the annual enrollment anniversary closest to the time of reporting will be considered the post-test. Successful maintenance is defined as 95% of families that initially reported high stress levels upon enrollment report declining stress on subsequent CHDRs.				comparison purposes we will use the CHDR completed first after enrollment with 12 months post enrollment and annually thereafter to measure progress over multiple years.	any barriers including appropriate referrals for comprehensive mental health services. Program level data will be analyzed for strengthening the program interventions including home visitor supervision and needed professional development.
20) Child's communication, language and emergent literacy	% of children showing improvement in the areas of communication / emergent literacy	# of children not on target in the areas of communication / emergent literacy/ # of age eligible enrolled children who have been screened with the ASQ	Ages and Stages Questionnaire – 3 <sup>rd</sup> edition	Decrease % of children not on target in the areas of communication / emergent literacy at 12 months post enrollment from comparing cohort 1 to subsequent cohorts. Children that score within the mean for	HV and parent	Ages and Stages Questionnaire – 3 <sup>rd</sup> edition (communication questions)	Children 0 – kindergarten entry enrolled in the program	ASQ – 3 <sup>rd</sup> edition prescribed 21 intervals of: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months. For benchmark reporting we will use the ASQ completed first after enrollment to	The ASQ results will be compared to children at risk to determine if children are developing as normal or within the standard deviation. Parents will be advised whenever children according to the ASQ guidelines fall within the “watch” category. The home visitor, with parents permission, will share the ASQ with the child's primary physician. The home visitor will also make a referral to the Area Education Agency for any child that indicates further evaluation is necessary.

Iowa Benchmark Plan – Final 2-1-12

				communication and maintain that score will also be counted as improved. We will measure the children as a composite and each year of enrollment will be treated as a separate cohort.				the ASQ completed closest to the one year anniversary of enrollment to compare progress over multiple years.	Supervisors will receive all ASQ scores and provide additional consultation when necessary. Home Visitors that have consistently low or high scores will be provided additional training on the use of the ASQ. At the state level, ASQ scores will be evaluated for geographic and demographic trends. In geographic areas where scores tend to be low, after calculating for risk, community solutions will be sought including evaluation of the quality of child care environments in the area.
21) Child's general cognitive skills	% of children demonstrating that are within the normal range for development	# of children demonstrating that their overall ASQ score falls within the normal range of development/ # of age eligible enrolled children that have been screened with the ASQ, 3 <sup>rd</sup> edition.	Ages and Stages Questionnaire – 3 <sup>rd</sup> edition	% of children demonstrating that their development falls within the normal range on the ASQ at the 12 month Children will be reported as a composite. In year one, we will create our baseline to compare in subsequent years. Each year will be a separate cohort. The intent would be that the more years of home visiting service received the higher the percentage of children scoring within the normal range on the ASQ. For maintenance purposes, 95% of the children scoring within the normal range of development will be considered as	HV and parent	Ages and Stages Questionnaire – 3 <sup>rd</sup> edition	Children 0 – kindergarten entry enrolled in the program	ASQ – 3 <sup>rd</sup> edition prescribed 21 intervals of: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months. For benchmark reporting we will use the ASQ completed first after enrollment to the ASQ completed closest to the one year anniversary of enrollment to compare progress over multiple years.	<p>The ASQ results will be compared to children at risk to determine if children are developing as normal or within the standard deviation. Parents will be advised whenever children according to the ASQ guidelines fall within the “watch” category. The home visitor, with parent’s permission, will share the ASQ with the child’s primary physician. The home visitor will also make a referral to the Area Education Agency for any child that indicates further evaluation is necessary.</p> <p>Supervisors will receive all ASQ scores and provide additional consultation when necessary. Home Visitors that have consistently low or high scores will be provided additional training on the use of the ASQ. At the state level, ASQ scores will be evaluated for geographic and demographic trends. In geographic areas where scores tend to be low, after calculating for risk, community solutions will be sought including evaluation of the quality of child care environments in the area.</p>

Iowa Benchmark Plan – Final 2-1-12

				meeting this construct.					
22) Child's positive approaches to learning including attention	% of families that have been trained by their home visitor in Positive Behavior Intervention Supports which supports regulating self control.	# of families that have been trained by their home visitor in Positive Behavior Intervention Supports / # of enrolled families	Positive Behavior Intervention Supports – Parent Modules	Increase the percentage of families that receive PBIS training by 12 months post enrollment, comparing cohort 1 to cohort 2. Year one families will be grouped into a cohort to create a baseline and compared to subsequent cohorts created in subsequent years. Successful maintenance is defined when 95% or greater of families report they have received PBIS training.	HV	Positive Behavior Intervention Supports – Parent Modules PBIS parent modules were developed by The Center on the Social and Emotional Foundations for Early Learning (CSEFEL). PBIS is a state-wide initiative. Please see the narrative for more information about PBIS parent modules	Families enrolled in the program	Annually, at least six months post-enrollment.	This construct only measures the receipt of training not behavior change. For CQI purposes we will measure the effectiveness of the PBIS parent modules by administering an evaluation yearly to all participating parents. Parent survey results will be incorporated into service delivery. We will also monitor for CQI purposes referrals for additional assessment.
23) Child's social behavior, emotion regulation, and emotional well-being	% of age eligible children scoring within the normal mean of the ASQ-SE	# of age eligible children scoring within the normal mean of the ASQ-SE/ # of age eligible enrolled children screened with the ASQ-SE	ASQ-SE	% of children scoring within the normal mean of the ASQ-SE at the 12 month ASQ-SE from cohort one to subsequent cohorts. Each year of enrollment will be treated as a separate cohort with the intent that the more home visiting services are provided the more likely the child will score within the normal mean.	HV and parent	ASQ-SE – please see the narrative for more information about the ASQ-SE	Age eligible children enrolled in the program (6 to 60 mths.)	At prescribed intervals (6, 12, 18, 24, 30, 36, 48, 60 mths.) For benchmark reporting purposes we will compare the ASQ-SE completed after enrollment with the ASQ-SE completed closest to the yearly enrollment anniversary to measure progress over multiple years.	For additional CQI efforts we will also measure the percentage of children screened with the ASQ-SE that are referred to the AEA for additional evaluation.  System and community level barriers will be analyzed and new strategies developed to overcome any barriers. Individual home visitor barriers will be addressed through supervision and professional development

Iowa Benchmark Plan – Final 2-1-12

				This construct will be considered to be met if 90% or higher of the children are scoring within the normal mean.					
24) Child's physical health and development.	% of children that are up-to-date on a schedule of age-appropriate preventative and primary health care according to the Iowa EPSDT schedule for well child care.	# of children that are up-to-date on a schedule of age-appropriate preventative and primary health care/ # of enrolled children	Primary source – parent interview	% of children that are up-to-date on a schedule of age-appropriate preventative and primary health care according to the Iowa EPSDT schedule for well child care comparing at the 12 month birthdate and subsequent annual birthdates. Each year of enrollment will be treated as a separate cohort with the intent that the more home visiting services are provided the more likely the child will increase or maintain if it is 95% or greater	HV	Parent Interview	Age eligible children	Annually 30 days before or after the child's birthdate.	For CQI purposes, home visitors will have a tickler loaded into the data system that will prompt them to remind families about upcoming well child exams.  System and community level negative trends will be examined for solutions such as the need for medical homes, lack of health care access, and other barriers.
<b>Benchmark 4: Crime or Domestic Violence</b> <i>Note: Iowa has chosen to report on domestic violence</i>									
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Definition of Improvement	Persons responsible	Source	Population	Schedule (Frequency)	Data Analysis Plan
<i>Domestic Violence</i>									
27) Screening for domestic violence	% of mothers with infants that were screened for domestic violence	# of mothers of infants that were screened for domestic violence/ # of	Domestic Violence Enhanced Home Visiting Project (DOVE)	Percentage of mothers of infants screened for DV will be compared in	HV	DOVE – has been tested and validated by research findings. See narrative section for more information.	Mothers enrolled in the program	Mothers will be assessed at birth, 3, 6, 12months postpartum.	Permission of the model developers to enhance the EHS and the HFA model will need to be gained to implement the DOVE. In addition, since it is a new

Iowa Benchmark Plan – Final 2-1-12

		mothers with infants that were enrolled in the program. Infant is a child 12 months or younger.	screening tool	cohort one to the percentage screened in subsequent cohorts. Each year of enrollment will be treated as a cohort. Maintenance will also be considered when 95% or greater of mothers with infants are screened.				Mothers must receive the screening at all recommended intervals to be counted toward meeting this measure.	screening tool for Iowa, additional training for all home visitors will need to be offered prior to implementation to ensure we implement with fidelity. We will also seek the assistance of our partners in Missouri who have experience with the screening tool. This is a sensitive subject for both parents and home visitors. Home Visitors must use caution to not put the parent at greater risk or jeopardize their own safety. At this point in time, we will routinely screen all mothers. It may be advised to only screen certain subsets of mothers. Unaddressed domestic violence can hamper any positive effects the home visiting program may have on the family including life-long child trauma as reported in the Adverse Childhood Experiences (ACE) study conducted by the CDC. In Iowa all health providers are encouraged to ask mothers if they feel safe in their home? Routine screening by home visitors will align with the systematic effort to identify and support families. We will seek technical assistance from HRSA and the model developer to determine an appropriate implementation plan.
28) Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries);	% of mothers with infants screened positive for DV and received referrals for relevant DV supports.	# of mothers with infants screened positive for DV and received referrals for relevant DV supports/ # of mothers with infants screened positive for DV	Administrative – Home visitor documentation of screening and referrals	Percentage of mothers with infants that screen positive for domestic violence and receive referrals for DV support in year one will create a baseline and be compared to subsequent years. Successful maintenance will be defined when 95% or greater of	HV	Home visitor documentation in REDCap	Mothers enrolled in program	Mothers will be assessed at birth, 3, 6, 12months postpartum. Mothers must receive all screenings at the recommended intervals to be counted as meeting this measure.	This construct measures referrals given. For CQI purposes we will also measure if the referral was helpful to the parent. Geographic differences may occur in the data since the resources vary greatly across the state particularly comparing rural Iowa to urban. Disparities that exist because of a lack of resources will be addressed at the state and local level. New strategies will be implemented to provide needed resources in rural areas of our state. The need for accurate and timely documentation is critical in measuring our CQI efforts for this measure. We will use the REDCap system to create a tickler to remind



Iowa Benchmark Plan – Final 2-1-12

				mothers who screen positive for DV receive referrals for supports					the home visitor to follow up with the parent to rate the helpfulness of the referral at follow up home visits.
29) Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.	% mothers screened positive for DV for which a safety plans completed	# of safety plans completed for families identified for the presence of DV/# of families that were identified for the presence of DV	Administrative – Home visitor documentation of screening and safety planning	Percentage of mothers that screen positive for domestic violence and have a safety plan in year One will create a baseline and be compared to subsequent years. Successful maintenance will be defined when 95% or greater meet this measure	HV	Home visitor documentation in REDCap. The safety plan will be created to contain all elements required by the DOVE project for an acceptable safety plan.	Mothers enrolled in program	Mothers will be assessed at birth, 3, 6, 12months postpartum. Mothers must receive all screenings at the recommended intervals to be counted as meeting this measure.	Safety plans will vary based on the severity of the risk assessed by the DOVE. In cases where a family is working with a DV advocate, the DV advocate may be the principal support to the family in the development of a safety plan.
<b>Benchmark 5: Family Economic Self-Sufficiency</b>									
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Definition of Improvement	Persons responsible	Source	Population	Schedule (Frequency)	Data Analysis Plan
30) Household income and benefits	%of families that show an improvement in income and benefits	# of families that show an improvement in income and benefits or maintain their income/ # of enrolled families	Parent Interview	Increase in total household income or the value of in-kind benefits or a combination of either income or in-kind benefits that result in a net gain for the household.	HV	Parent Interview	Parents residing in the home with the targeted child enrolled in the program	Enrollment and one-year post enrollment.	Data will be reviewed at enrollment and at 12 months post enrollment. An analysis will be completed down to the home visitor level. System level and community level barriers to employment will be addressed by implementing new strategies to overcome these barriers. Individual worker barriers will be addressed through supervision and professional development
31) Employment or Education of adult members of the household	% of families that show an improvement in education or employment	# of families that show an improvement in employment or education / # of enrolled families	Life Skills Progression Instrument #12, #13, #14, #15	Increase in the number of families that show improvement in any one of these scales from Pre-test to post-test. Scores of three, four or five on scales 12 or 13 and scores of two, three, four or five on scales	HV	LSP See narrative that describes the validity and reliability of the LSP	Parents residing in the home with the targeted child enrolled in the program	Enrollment, every 6 months until case closed.	Data will be reviewed at enrollment and every six months thereafter and at case closing. An analysis will be completed down to the home visitor level. System level and community level barriers to employment and training will be addressed by implementing new strategies to overcome these barriers. Individual worker barriers will be addressed through supervision and professional development

Iowa Benchmark Plan – Final 2-1-12

				14 or 15 that are maintained are also considered improvement. For comparison purposes, the LSP completed at enrollment will be considered the pre-test and compared to the LSP completed at the annual anniversary of the enrollment closest to the time of the report.					
32) Health insurance status	% of household members with health insurance coverage	# primary adult and index child with health insurance coverage/ # of primary adults and index children	Life Skills Progression Instrument, Scale #33	Increase in the number of families that show improvement from pre-test to post-test. Scores of three, four or five that are maintained are also considered improvement. For comparison purposes, the LSP completed at enrollment will be considered the pre-test and compared to the LSP completed at the annual anniversary of the enrollment closest to the time of the report.	HV	LSP See narrative that describes the validity and reliability of the LSP	Primary parent residing in the home with the targeted child enrolled in the program	Enrollment, every 6 months until case closed.	Data will be reviewed at enrollment and every six months thereafter and at case closing. An analysis will be completed down to the home visitor level. System level and community level barriers to health insurance coverage will be addressed by implementing new strategies to overcome these barriers. Individual worker barriers will be addressed through supervision and professional development
<b>Benchmark 6: Coordination and Referrals</b>									
Construct	Performance Measure	Operational Definition	Measurement (Tool or	Definition of Improvement	Persons responsible	Source	Population	Schedule (Frequency)	Data Analysis Plan

Iowa Benchmark Plan – Final 2-1-12

			Administrative)						
33) Number of families identified for necessary services	% of families screened for mental health, domestic violence, or substance abuse services	# of families screened for mental health, domestic violence, and substance abuse services/# of families enrolled	Administrative – HV documentation in REDCap	Percentage of families screened for mental health, domestic violence and substance abuse will increase from year one to subsequent years. A rate of 95% or higher that is maintained is also defined as successfully meeting this measure.	HV	Administrative Data – HV documentation in REDCap. Actual screening tools will vary from the EPDS, DOVE to a yet to be determined screening tool for SA.	Parents of the targeted child that reside in the same household.	At least annually or more frequently depending upon the protocol of the individual screening developer	<p>These are sensitive topics so care will be used to make the screening a routine part of the home visiting program. This should also help alleviate any anxiety the home visitor may feel about discussing these sensitive issues. At the local level, supervisors will carefully evaluate any trend data for individual home visitors to identify those that may benefit from additional consultation or training.</p> <p>At the state level, care will be used to evaluate the impact of available referral sources to positively identifying families with these issues. In areas where there may be a limited cadre of referral sources, fewer families may be identified as needing the services. Home Visitors may feel that they have an “ethical” obligation to not identify potential problems if they do not have adequate referral sources at their disposal.</p>
34) Number of families that required services and received a referral to available community resources	% of families screened for mental health, domestic violence, or substance abuse services that required services that were referred to available community resources.	# of families screened for mental health, domestic violence, or substance abuse services that required services that were referred to available community resources/# of families screened that required services	Administrative – HV documentation in REDCap	Percentage of families screened for mental health, domestic violence and substance abuse and required services and received a referral to available community resources will increase or be maintained from year one to subsequent years. Maintenance is defined as a rate of 95% or higher maintained	HV	Administrative Data – HV documentation in REDCap. Screening results that require a referral will be noted in the data collection system.	Parents of the targeted child that reside in the same household.	At least annually	<p>At the state level, care will be used to evaluate the impact of available referral sources to positively identifying families with these issues. In areas where there may be a limited cadre of referral sources, fewer families may be identified as needing the services. Home Visitors may feel that they have an “ethical” obligation to not identify potential problems if they do not have adequate referral sources at their disposal.</p> <p>An additional CQI protocol will be to evaluate the effectiveness of the referral. A tickler will be established for the home visitor to follow up with the family to gauge the helpfulness of the referral to the family.</p>
35) MOUs: Number of	Number of MOUs between	# of MOUS between the	Administrative Data	Percentage of	MIECHV administrative	Administrative data on file at IDPH	Social service agencies at the	At least annually	MOUs may already be in place in Black Hawk County since we are

Iowa Benchmark Plan – Final 2-1-12

Memoranda of Understanding or other formal agreements with other social service agencies in the community	the home visiting program and other social service agencies in the community	home visiting program and other social service agencies/ # of MOUS identified by IDPH with community input as needed for optimal programming.		MOUS that are in place between the MIECHV program and social service agencies in the community as identified by IDPH with community input increases each year of operation. Baseline will be established in the first quarter of service and will be compared to subsequent years. Each program site (targeted community) will be evaluated separately but reported as a composite. Successful maintenance will be defined as MOUS established with 98% of identified partners.	staff		state and local level		expanding an existing program. That may cause an inflation of numbers in year one that is not reflective of establishing a new program.  The MIECHV staff in conjunction with the community advisory board will create a resource list reflective of community resources that families need in order to be successful. MOUs will be obtained from those resources. The prospective list will be updated at least annually and as needed in between the annual updates.
36) Information sharing: Number of agencies with which the home visiting provider has a clear point of contact.	Number of releases of information that the family has signed between the home visiting program and other service providers.	# of releases of information that the family has signed between the home visiting program and other service providers/ # of ROI's identified as being needed to enhance services for enrolled families.	Administrative Data in Home Visitor Client Record and supervisory records.	Increase in the rate of ROI's in the family file with different organizations compared to the number of ROI's identified by the supervisor as being needed to provide optimal services. This will be gathered at the worker level but	HV	Administrative data	Parents residing with the targeted child enrolled in the program	annually	For CQI purposes, we will also be comparing the rate of ROI's between our urban community and our rural community. In rural communities there is a tendency to share information without a written ROI. If the rate is significantly lower, a sampling of case files by the supervisor will occur to determine the cause of the lower rate.

Iowa Benchmark Plan – Final 2-1-12

				reported as a state composite. Successful maintenance will be defined when our rate reaches and maintains at 95%. Family's may also choose to not sign a ROI. These documented incidences will not count in the denominator.					
37) Number of completed referrals	% of referrals provided that were acted upon by the family	# of referrals provided that were acted upon by the family/ # of referrals provided	Administrative Data in Home Visitor Client Record	Increase in the rate of referrals that were acted upon between year one and subsequent years. Successful maintenance is defined when the rate of completed referrals reaches 95%.	HV	Administrative data	Parents residing with the targeted child enrolled in the program	annually	A tickler will be developed in the REDCap system when a referral is given for the home visitor to follow up on the referral with the family at the next home visit. In addition for CQI purposes, the helpfulness of the referrals provided will be evaluated by parents annually. An analysis of the parent evaluation will be completed to determine any trends amongst workers or any specific communities. Workers that seem to have a higher success rate will have further exploration about what personal attributes do they possess that motivates their clients to follow through on referrals.